PHYSICIAN TELEPHONE CONSULTATION FORM
CLTC TELEMONITORING SERVICE
FOR
SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ONLY DOCTOR
OR NURSE

ATTENDING PHYSICIAN_____ **DATE**_____

DATE	TIME	☐ CALL BACK	☐ RETURNING YOUR CALL
		☐ URGENT	☐ FOLLOW-UP ORDERS

PATIENT NAME	CALLER	
(H) (WK.)	**ASSESSMENT RESULTS**	
☐ PROGRESS SEEN	WEIGHT	
PRESENTING PROBLEMS	O2	
	HR	
	GLUCOSE	
	BP	
PHYSICIAN'S INSTRUCTIONS	**PLAN**	
	NURSE SIGNATURE	

PHYSICIAN SIGNATURE_____ DATE _____